Name: ______________________________________ Date: _____________________

Medical History

Are you under a physician's care now? Yes No If yes, who and why? ___________________________________

____

Have you been hospitalized in the past 5 years? Yes No If yes, why? ____________________________________

____

PLEASE MARK YES OR NO.

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease			Liver or Kidney Disease			Snoring/Sleep Apnea		
High Blood Pressure			Diabetes			Stomach/Intestinal Disease		
Angina/Chest Pain			Stroke			Venereal Disease		
Artificial Heart Valve			Fainting, convulsions, Epilepsy			HIV/AIDS		
Heart Pacemaker			Psychiatric Treatment			Cortisone/Steroids		
Blood Disorder			Arthritis			Do you get cold sores or canker sores?		
Excessive Bleeding			Cancer			Do you smoke or chew?		
Lung Trouble			Radiation Treatment			Are you pregnant?		
Tuberculosis			Chemotherapy			Any replacement joints?		
Hepatitis, Jaundice			Sinus Trouble					

If you marked yes to any of the above conditions, please explain:

____

____

Do you have any disease, condition or problem not listed above that you think I should know about?

____

____

Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Codeine/Aspirin
- ☐ Local Anesthetic/Novocaine
- ☐ Latex Rubber
- ☐ Other ___________________

Please list all medications you are currently taking: (if you have a list, I can make a copy of it)

____

____

Medical Updates

I have read my medical history dated __________ and confirm that it adequately states past and present conditions.

Date:	Exceptions	Patient's Signature	BP	Reviewed by
________	__________________________	______________________	_________	___________________
________	__________________________	______________________	_________	___________________
________	__________________________	______________________	_________	___________________
________	__________________________	______________________	_________	___________________
________	__________________________	______________________	_________	___________________
________	__________________________	______________________	_________	___________________

Dental History

When was your last dental visit? Mo/Yr _______ Full mouth x-ray ______ Dentist ____________________
Have you come to this office today for relief of pain? Yes No If yes, where is the pain?_________________
Have you had the pain for more than 3 weeks? Yes No Do your gums bleed when brushing? Yes No
Have you been told you have pyorrhea (gum/bone disease)? Yes No
Have you had orthodontic treatment? Yes No
Have you ever had professional instruction on dental home care? Yes No
How many times a day do you brush? ____________
How many times a week do you floss? ____________
How many times a week do you toothpick/other? ____________
What type of toothbrush bristles do you use? Soft Medium Hard
Do you have any un-replaced missing teeth? Yes No Has it been suggested to replace them? Yes No
Is any part of your mouth sensitive to temperature or pressure? Yes No If yes, which part? ____________
Does food catch between your teeth? Yes No If yes, where? ____________________________________
Do you have sores or growths in your mouth? Yes No
Do you have an unpleasant odor or taste in your mouth? Yes No
Do you always have something to be treated or repaired when you visit the dentist? Yes No
Do you feel in the past you have required a lot of dental work? Yes No
Do you wish to talk to the dentist privately about any problem? Yes No
Are you deeply concerned about the finances required to restore your mouth to a healthy condition? Yes No

Esthetic Evaluation

	Y	N
Are you happy with your teeth and their appearance?		
Are you self-conscious about your teeth when you smile?		
Do you ever cover your smile with your hand?		
Do you wish your teeth were whiter?		
Do you wish your teeth were shaped differently?		
Do you have discolored teeth?		
Have esthetic dental procedures ever been recommended to you?		

Occlusal Screening

	Y	N
Do you clench or grind your teeth during the day?		
Are you aware of clenching or grinding your teeth at night?		
Are your jaws or teeth tired when you awaken?		
Do you suffer from chronic headaches of any kind?		
Do you experience chronic neck or shoulder pain?		
Have you ever had pain in your jaw joints, the sides?		
Do your jaws, or have they ever, clicked or popped when you open your mouth?		
Have you ever experienced difficulty moving your jaw or opening your mouth wide?		
Do you chew on only one side of your mouth?		

I have completed this preclinical examination questionnaire to the best of my knowledge and agree to undergo a complete oral examination.
Print Name__________________________ Sign Name ____________________________ Date __________